Division of Health Care Finance and Policy
Claims Update – November 3, 2008

Topic: Required submission of ERBD claims within ninety (90) days of the date of write off.

Update: Effective November 17, 2008, the Division of Health Care Finance and Policy (Division will activate the claims edit requiring that all ERBD claims be submitted within ninety (90) days from the date of write off. Providers must attempt collection for a minimum of 120 days; however, they may work accounts longer. Claims for ERBD must be submitted within 90 days after these accounts were deemed uncollectible and written off the provider's books.

Topic: Present on Admission Indicator requirement for 837-I claims

Update: As referenced in the Division's August 7, 2008 claims update, the Division will be requiring the Present on Admission (POA) indicator for inpatient 837-I claim submissions (Type of Bill, 111, 117, 118). This is consistent with Medicare requirements and was scheduled to be effective as of October 1, 2008. Effective November 17, 2008, the Division will be activating the POA claim edit. 837-I claims submitted as of November 17 that do not contain the POA indicator will be denied.

Topic: Posting of 835's on INET

Update: It was previously noted that the HSN 835 File would be produced within three business days of the 837 submission. In order to insure that providers are getting information in the appropriate order and can make decisions on whether or not to post the 835, the HSN 835, effective November 3, 2008, will now be produced within 3 business days of the Validation Report creation. This allows providers time to review the Validation Report for claim results and determine if they want to post a particular 835.

This change only affects the production and delivery of the HSN 835. The Validation Report will still have a two to three day delay between receipt of the 837 file and report creation, barring any weekends, holidays and/or unforeseen system downtime.

Topic: Identification and submission of Inpatient Psych Claims

Update: Effective November 17, 2008, the Division will activate edits regarding the proper coding of provider 837-I Inpatient Psych claim submissions. The Division posted an August 11, 2008 billing update indicating that providers would be required to identify their inpatient psychiatric claims with the appropriate National Provider Identifier (NPI). This requirement would allow the Division to implement Medicare pricing for inpatient psychiatric claims.

The Division developed several options to ensure appropriate payment on these claims and sought input from providers regarding the option that is most operationally feasible for the majority of providers. Available options included: *Distinct NPI required for Psychiatric Units; Main Organization NPI with taxonomy codes* and *DHCFP Organization ID.*

837-I inpatient psych claims that are not properly coded will result in their not being identified and processed as a psych claim.